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Editorial

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The articles in this issue consider the use of health services among Medicaid beneficiaries suffering from schizophrenia with different living situations (Gilmer *et al.*), antipsychotic medication use patterns and the costs of care of schizophrenic patients (Loosbrook *et al.*), approaches to the integration of psychiatric and substance abuse services for homeless individuals (Rosenheck *et al.*) and the allocation of time to mental health care, education, administration and research activities among mental health providers at veterans health administration facilities (Sullivan *et al.*).

Gilmer *et al.* (p. 59) examine the use of inpatient and outpatient mental and medical services by individuals with schizophrenia residing in assisted living facilities, as compared with service use by schizophrenic patients living independently and by those who are homeless. The study uses information on diagnosis of schizophrenia, living situation, age, ethnicity, co-morbid substance use disorder and psychosocial functioning, as well as claims data on case management, therapy, crisis stabilization, medication supervision, day treatment, drug treatment and inpatient psychiatric and medical admissions from 1998 to 2000. The authors report that residents of assisted living facilities had a greater use of outpatient mental health services and a lower rate of psychiatric and medical hospitalizations. Pharmacy costs and total health care costs were highest for patients in assisted living facilities. The authors conclude that assisted living facilities appear to allow ready access to outpatient services and it may be the case that reports of substandard care in the literature apply only to certain types of such facilities.

Loosbrook *et al.* (p. 67) analyze the impact of antipsychotic medication use patterns on the costs of care for individuals with schizophrenia in an employment-based health insurance sample. They evaluate the use of outpatient services, including antipsychotic medication, by 2,082 patients over the course of one year. The authors identify five main medication use patterns during the observation period: (i) *Not treated*, (ii) *Monotherapy* (only one antipsychotic medication during the period); (iii) *Switch category* (the initial treatment was discontinued and a subsequent prescription for another antipsychotic medication was introduced); (iv) *Augment* (the patient, on antipsychotic medication at the start of the observation period, filled subsequent prescription[s] for that same medication and for at least one additional antipsychotic drug); and (v) *Concomitant* use (more than one antipsychotic medication at the start of the observation). They report that 26% of individuals with a diagnosis of schizophrenia did not receive antipsychotic medication in the outpatient setting, 52% were in Monotherapy and 2% in Concomitant use. The Switch (13%) and Augment (7%) categories were associated with higher total costs with respect to Monotherapy. The authors suggest ideas for future research.

Rosenheck *et al.* (p. 77) articulate two approaches to the integration of psychiatric and substance abuse services, one involving an integrated team model and the other a collaborative relationship between agencies. The sample was made up of dually diagnosed homeless people (N = 1,074) who participated in a demonstration project. A client self-report was used to evaluate outcomes in the domains of severity of psychiatric symptoms, alcohol and drug consumption, number of homeless days, and health and social services use. The authors surveyed the demonstration project's case managers to obtain data on the integration of psychiatric and substance abuse services, with a view to assessing (i) the proportion of clients who received substance abuse services directly from the case management teams and the proportion who received services from other agencies; and (ii) the perceived quality of the relationship (in terms of communication, cooperation and trust) between providers–both within teams and from one agency to another. They report significant associations between perceptions of communication, cooperation and increased clinical service use, and found that treatment entirely by a single team was associated with poorer housing and psychiatric outcomes. The authors consider these results to be illustrative rather than conclusive due to study limitations.

Sullivan *et al.* (p. 89) investigate the factors associated with time allocation by mental health providers across clinical, administrative, educational and research activities in veteran administration mental health services. Using a short, self-report questionnaire, they surveyed 997 mental health providers at 10 Veterans Health Administration (VHA) facilities. The authors report that on an overall basis, providers spent most of their time on clinical activities (77%), followed by administrative tasks (11%) and educational activities (10%). Only 2% of all mental health providers' time was allocated to research activities, a finding the authors highlight given that (i) six of the ten examined facilities are academically affiliated; (ii) 20% of the providers hold academic positions; (iii) research is one of the central missions of the VHA); and (iv) in a 2002 national survey of VHA researchers, 79% stated that research opportunities and support were extremely important for recruiting and retaining high-quality VHA clinicians. According to the authors, recent trends—an increase in the demand for mental health

services in these facilities (the number of individuals seeking mental health care has increased by 16%) and a decrease in the necessary resources (the number of mental health positions has fallen by 24%)–may have prompted this pattern of allocation.